DSHS
WASHINGTON STATE
Department of Social and Health Services

Documentation Request for Medical Condition and Residual Functional Capacity

Dear Health Care Provider:

For adult clients to get public assistance (TANF), they are required to work, actively look for work, or get training to work for up to 40 hours per week. Some clients may not be able to meet this requirement because of health-related issues. These clients may need temporarily deferral from a work activity, may be able to participate but for a limited number of hours, or may need to avoid certain types of work activities.

_____ (name of client) told us that they, or a family member they care for, has a medical, mental or emotional condition, which prevents or limits their ability to work, look for work or participate in training to work.

Please complete the enclosed form to describe these medical limitations. **If any condition duration is longer than three months, please provide copies of objective medical evidence (chart notes, laboratory, imaging, and any other diagnostic test) to verify condition.** Please bill DSHS, not the client, for any costs related to providing this information.

We will use this information to determine the level of required participation (up to 40 hours per week) in these types of activities, and any limitations to consider in developing a customized activity plan based on the client's medical needs.

Please provide this completed form and any additional objective medical evidence by _____ (deadline date). If we do not receive any medical information, we may require full-time participation, up to 40 hours a week, in work, job search or training to work as described above. If the requirements are not met, cash benefits may be reduced or terminated.

If you have any questions or need more time to send us the information, please call me at _____ (number of worker). You may send this completed document and any medical evidence to our statewide fax number at 1-888-338-7410 or mail it to DSHS, CSD – Customer Service Center, PO Box 11699, Tacoma WA 98411-6699.

Thank you,

_____
Worker's Name

DSHS
WASHINGTON STATE
Department of Social and Health Services

WORKFIRST

Documentation Request for Medical Condition and Residual Functional Capacity

CLIENT NAME	DATE OF BIRTH	CLIENT IDENTIFICATION NUMBER
NAME OF PATIENT EVALUATED IF DIFFERENT THAN THE CLIENT NAMED ABOVE		
WORKFIRST STAFF NAME		TELEPHONE NUMBER
COMMUNITY SERVICES OFFICE (CSO) ADDRESS		

To help the department determine the limitation(s) of the above-named individual, please provide the following information:

1. Does this person have specific (please check the box) ☐ physical, ☐ mental, ☐ emotional, or ☐ developmental issues that require special accommodations or considerations?
   ☐ Yes ☐ No

2. If yes, what is the type of condition(s) and the diagnosis?

   Is this supported with objective medical evidence (testing, lab reports, etc.)?
   ☐ Yes. If yes, please attach supporting evidence to this form.
   ☐ No. If no, please address in Question 8.

3. Do the medical condition(s) listed above limit the person's ability to work, look for work, or prepare for work?
   ☐ Yes. If yes, check any applicable examples below. ☐ No

   Examples of limitations include the ability:

   ☐ to lift heavy objects
   ☐ stand or sit for long periods of time
   ☐ follow instructions
   ☐ bend over
   ☐ reach above
   ☐ memory retention
   ☐ concentrate for extended periods of time,
   ☐ make repetitive motions,
   ☐ interact with people,
   ☐ tolerate exposure to chemicals, synthetic materials
   ☐ gross or fine motor skills

   Please describe any other specific limitations not listed above:

   If yes, this person should be limited to the following participation limits per week:
   ☐ 0 hrs (unable to participate) ☐ 1 – 10 hrs ☐ 11 – 20 hrs ☐ 21 – 30 hrs ☐ 31 – 40 hrs.

Barcode label

10353

4. Does this person have any limitations with lifting and carrying? ☐ Yes ☐ No
If yes, this person has the following limitations:

☐ Severely limited: Unable to lift at least 2 pounds or unable to stand or walk.

☐ Sedentary work: Able to lift 10 pounds maximum and frequently* lift or carry such articles as files and small tools. A sedentary job may require sitting, walking and standing for brief periods.

☐ Light work: Able to lift 20 pounds maximum and frequently* lift or carry up to 10 pounds. Even though the weight lifted may be negligible, light work may require walking or standing up to 6 out of 8 hours per day, or involve sitting most of the time with occasional* pushing and pulling of arm or leg controls.

☐ Medium work: Able to lift 50 pounds maximum and frequently* lift or carry up to 25 pounds.

☐ Heavy work: Able to lift 100 pounds maximum and frequently* lift or carry up to 50 pounds.

* The person is able to perform the function for 2.5 to 6 hours in an 8-hour day and not necessary that performance be continuous.

5. Does this person's condition(s) impact their ability to access services (such as using the telephone, receiving treatment, making and keeping appointments, using transportation services, or finding locations of services) or advocating for themselves?
☐ Yes ☐ No

If yes, describe:

6. Is this person's condition permanent and likely limit their ability to work, look for work, or train to work?
☐ Yes ☐ No; if the condition isn't permanent, how long will this person's condition likely limit their ability to work, look for work, or train to work. Please use the space below to indicate the number of weeks or months:

_____ Number of weeks, or
_____ Number of months.

7. a. Is there a specific treatment plan you made to address this person's health-related condition?
☐ Yes ☐ No

If yes, describe the treatment plan including types of services provided, duration, and frequency of treatment appointments.

b. Who will be providing and monitoring the person's ongoing treatment plan?

8. Are there specific issues that need further evaluation or assessment? ☐ Yes ☐ No

   If yes, please specify what type of assessment or evaluation might be needed to determine medical conditions and plan to address. Please indicate if any further referrals to the specialist are required.

9. If the patient being evaluated is different than the client named because of the impact the patient's condition has on the client's ability to participate, due to needing to care for the person in their home, please complete the following.

   Given the child's / adult relative's condition, check the appropriate box:

   ☐ The parent / caretaker can participate outside the home 0 – 10 hours per week.
   ☐ The parent / caretaker can participate outside the home 11 - 20 hours per week.
   ☐ The parent / caretaker can participate outside the home 21 - 30 hours per week.
   ☐ The parent / caretaker can participate outside the home more than 30 hours per week.
   ☐ Please contact me for further information.

How long do you expect the parent will need to provide this level of care: _____ Number of weeks

_____ Number of months

Medical / Mental Health Care Provider / Other Professional

SIGNATURE	DATE	TELEPHONE NUMBER

PRINTED NAME AND TITLE

MAILING ADDRESS	CITY	STATE	ZIP CODE
		WA	

Authorization to Release Information

I authorize _____ to release to the Department of Social and Health Services the information on this form and any medical record information that substantiates the illness/injury condition that prevents me from working, solely to evaluate my capacity to participate in the WorkFirst Program. I understand that this release specifically includes diagnostic testing or treatment information concerning mental health, alcohol or drug abuse and the result of Sexually Transmitted Diseases (STD), including HIV/AIDS, when such information is part of the record. (Revised Code of Washington (RCW) 78.24.105)

PATIENT'S SIGNATURE	DATE

INSTRUCTIONS

DSHS WorkFirst Case Manager / Social Worker: The purpose of this form is to assist you in developing an Individual Responsibility Plan when, as a result of a medical condition, or incapacity, there is an impact on the person's ability to work, look for work, attend training and/or access services. **Use of this form is NOT mandatory if other documentation exists.** You may give this form to the applicant / recipient to take to the appropriate professional service provider for completion or you may provide this directly to the provider by fax or mail. If you choose to mail this form, obtain the client's signature on the last page, and enclose prepaid envelope.

DSHS Customer: The purpose of this form is to gather information from a medical provider that will assist your Case Manager in reviewing your health issues and creating an Individual Responsibility Plan that best fits your specific needs and limitations.

Physician / Health Care Provider: For adult clients to get public assistance (TANF), they are required to work, actively look for work, or get training to work for up to 40 hours per week. Some clients may not be able to meet this requirement because of health-related issues. These clients may need a temporary deferral from a work activity, may be able to participate but for a limited number of hours, or may need to avoid certain types of work activities. Please complete this form and give it to the client, send it to our statewide fax number 1-888-338-7410, or send it to the WorkFirst Case Manager at DSHS, CSD – Customer Service Center, PO Box 11699, Tacoma WA 98411-6699. Send us any notes, letters, or other documentation you already have in your records that address the person's limitations.